Provider Handbook 2021

Table of Contents

Vision Statement
Mission Statement
10 Guiding Principles
Our Partners
YCCO Contact Information

Eligibility Verification
Coordination of Benefits
Member PCP Assignment
Changing PCPs
Access to Care
Urgent and Emergency Services
Crisis Management
Appointment Availability and Scheduling
Non-Scheduled Walk-Ins

YCCO Member’s Rights and Responsibilities
American Disabilities Act (ADA), Cultural Considerations & Non-Discrimination
Interpretation Services
Advance Directives
Seclusion and Restraint

Transportation for OHP Members

Traditional Health Workers

Member Grievance System

Provider Rights and Responsibilities
Provider Relations
CIM3-The YCCO Provider Portal
Credentialing & Contracting
Performance Monitoring
Covering Providers and On-Call Arrangements
Communication Among Providers/Care Coordination
Filing Claims
Overpayment
Third Party Liability
Timely Claim Submission
Billing a Member
Discharge and Disenrollment of Members

Benefits
The Prioritized List of Health Services
Excluded Services & Limitations
Clinical Practice Guidelines
Services Covered by DMAP
Tobacco Cessation
Prior Authorization
Second Opinion

Privacy and Confidentiality in the Medical Record

Pharmacy Program

Care Management
Exceptional Needs Care Coordination/Intensive Care Coordination Services

Fraud, Waste and Abuse

YCCO Policies & Procedures

Appendix A

Welcome to Yamhill Community Care (YCCO)!

The YCCO Vision Statement
"A unified health community that celebrates physical, mental, emotional, spiritual, and social well-being."

The YCCO Mission Statement
"Working together to improve the quality of life and health of Yamhill Community Care Organization members by coordinating effective care."

The YCCO 10 Guiding Principles
1. Health Education
2. Accountability
3. Innovation
4. Evidence-Based Clinical Care
5. Transparency
6. Shared Responsibility
7. Member Empowerment
8. Wellness Promotion
9. Equity
10. Stewardship

Our Partners
YCCO has partnerships with several organizations to provide the best care to our members.

The YCCO partners:

Performance Health Technology
Providence Plan Partners
Yamhill County Health and Human Services
Capitol Dental Care
WellRide/First Transit

The YCCO provider manual is a resource that contains information on your responsibilities as a YCCO network provider, health plan benefit information and required policies and procedures. Should you be contracted with one of our partners you may be held to additional standards contained through their contracting process and an additional provider manual or handbook.

YCCO Contact Information

Telephone Numbers:
Customer Service: 503-488-2800
855-722-8205
TTY/TDD: 800-735-2900 or 711

Administrative Office: 503-376-7420

Administrative Office Fax: 503-376-7436

Addresses
Administrative Office:
807 NE Third Street
McMinnville, OR 97128

Mailing Address:
PO Box 5490
Salem, OR 97304

Administrative Office Email: info@yamhillcco.org

YCCO Website: www.yamhillcco.org

Eligibility Verification

Each YCCO member receives a Member Identification Card. Information on the card will help explain the patient's eligibility, indicates the Primary Care Provider or Clinic, with the appropriate telephone numbers for YCCO Customer Service, Preauthorization and Pharmacy information. The cards also explain to members how to reach our:

- Oral Health Care Organization, Capitol Dental Care,
- Behavioral Health Team, Yamhill County Health and Human Services, and
- Non-emergent medical transportation agency, WellRide.

Please remember that a Member Identification Card is not a guarantee of eligibility. YCCO has no mechanism for retrieving the Member Identification Card when the member is no longer eligible. Please utilize Customer Service, MMIS or the CIM3 Portal to verify current eligibility.

It is the responsibility of the provider to verify a patient is eligible on the date of service and that you or your clinic is the primary care provider. The provider assumes full financial risk of serving a patient not confirmed as eligible for the service provided on the date of service.

To request CIM access or to verify eligibility contact Customer Service at 855-722-8205.

Coordination of Benefits

Situations may arise in which charges for a member's health services are the responsibility of a source other than the Plan. The following is a list of situations that a YCCO member may encounter:

- Workers' Compensation
- Liability Auto Insurance
- Third Party Payer

Coordination of Benefits ensures that the appropriate insurers are held responsible for the cost of a member's health care and is one of the factors that can help hold down premiums and overall health care costs. Always ask members if they have additional insurance coverage or when being seen for an injury if this injury is related to a work or auto accident.

Member Primary Care Provider (PCP) Assignment

All YCCO members have a primary care provider (PCP) who manages their medical needs. Members are assigned to PCP clinics or offices. Members are not assigned to individual practitioners unless the practitioner has a solo practice.

PCPs are automatically assigned when the member enrolls with YCCO. Auto assignment is based on where the member lives.

Members have 30 days from the date of enrollment to change their PCP assignment.

PCP Assignment & Changing PCPs

Members can call Customer Service within the first 30 days of their enrollment with YCCO to select a new PCP. PCPs, at the request of the member, can help a member select their clinic as the PCP by calling Customer Service. PCP change requests go into effect at the time the request is made.

After their first 30 days with their CCO, members may change their PCP **no more than twice a year.** Exceptions will be made for members who have had a change of residence or who have been discharged from their PCP clinic.

Claims for PCPs who see a member not assigned to them or their clinic without a referral from the assigned PCP will receive a denial.

Download your member roster timely for newly assigned members and check eligibility regularly to ensure that members are eligible and assigned to you or your clinic.

If you have questions about a claim denial, a referral or to make a PCP change at the request of the member contact Customer Service.

Members receive an ID card from YCCO when they enroll and any time they change their PCP, their name, benefits, or household members.

Access to Care

YCCO assures the established provider network can serve the expected enrollment in the service area. This is accomplished by evaluating the network of providers is sufficient in number, mix and geographic distribution to offer an appropriate range of preventative, primary care, specialty, and long-term service supports for physical, oral, and behavioral health. The network will have adequate access and if a participating provider is not available within the network, accommodations will be made for out of network coverage.

YCCO ensures the network and services provided by the network are sufficient to deliver accessible, high quality, culturally and linguistically appropriate services to Members. Review of providers, network composition, capacity, utilization, and other data is done at minimum annually and when a significant change to the network occurs. These reviews assure the appropriate range of preventive, primary care, and specialty services. If through this review, a disparity is identified, YCCO activity works to address the gap through contracting and other strategies.

Urgent, Emergency and Post-Stabilization Services

YCCO does not:

- Require prior authorization for urgent and emergency services, members may access these services 24 hours a day, 7 days a week.
- Limit what constitutes an emergency medical condition on the basis of lists of diagnosis or symptoms.
- Hold members liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
- Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's PCP of the member's screening and treatment within 10 days of the presentation for emergency services.
- Deny payment for treatment obtained under either of the following circumstances:
    - A member had an emergency medical or dental condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition or emergency dental condition.
    - A representative of YCCO instructs the member to seek emergency services.

The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. Based on this determination, YCCO is liable for payment.

Post-stabilization services are covered and paid for in accordance with 42 CFR 422.113 as follows:

- YCCO is responsible for post-stabilization care services obtained within or outside the YCCO network that are pre-approved by a contracted partner or other YCCO representative;
- YCCO is responsible for post-stabilization care services obtained within or outside the YCCO network that are not pre-approved by a contracted partner or other YCCO representative, but are administered to maintain the member's stabilized condition within 1 hour of a request to YCCO or the YCCO contracted partner for preauthorization of further post-stabilization care services;
- YCCO is responsible for post-stabilization care services obtained within or outside the YCCO network that are not pre-approved by a contracted partner or other YCCO representative, but administered to maintain, or approve, or resolve the member's stabilized condition if:
    - YCCO does not respond to a pre-authorization request within 1 hour;
    - YCCO cannot be contacted; or
    - YCCO or contracted partner and treating physician cannot reach and agreement on member's care and plan physician isn't available for consultation. In this situation, YCCO must give treating physician opportunity to consult with plan physician and treating physician may continue with care of member until plan physician is reached or one of the

criteria in 42 CFR 422.113 is met.; and YCCO will limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he/she/they had obtained the services through the YCCO network. For cost-sharing purposes, post-stabilization care services begin upon inpatient admission.

YCCO's financial responsibility for post-stabilization services it has not approved ends when:

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care;
- A plan physician assumes responsibility for the member's care through transfer;
- YCCO or YCCO contracted partner and treating physician reach agreement regarding the member's care; or
- Member is discharged.

Additional information on urgent, emergency, and post-stabilization services is located in the YCCO Emergency, Urgent and Post-Stabilization Services Policy and Procedure.

Crisis Management

YCCO and/or partners have monitoring systems that provide for mental health emergency, including post-stabilization care services and urgent services for all members on a 24-hour 7 day-a-week basis.

- YCCO ensures that an emergency response system is provided for members who need immediate, initial, or limited duration response for potential behavioral health emergency situations or emergency situations that may include behavioral health conditions, including:
  - Screening to determine the nature of the situation and the person's immediate need for Covered Services;
  - Capacity to conduct the elements of a Behavioral Health Assessment that are needed to determine the interventions necessary to begin stabilizing the crisis situation;
  - Development of a written initial services plan at the conclusion of the Behavioral Health Assessment;
  - Provision of Covered Services and Outreach needed to address the urgent or crisis situation;
  - Linkage with the public sector crisis services, such as Mobile Crisis Services and diversion services.
- The crisis management system must include the necessary array of services to respond to behavioral health crises, which may include crisis hotline, 24-hour mobile crisis team, walk-in/drop-off crisis center, crisis apartment/respite and short-term stabilization unit capabilities.
- YCCO will ensure access to mobile crisis services for all members in accordance with OAR 309-019-0105, and 309-019-0300 through 309-019-0320 included

below to promote stabilization in a community setting rather than arrest, presentation to an emergency department, or admission to an acute care facility.

Additional information on urgent, emergency, and post-stabilization services is located in the YCCO Emergency, Urgent and Post-Stabilization Services Policy and Procedure.

Appointment Availability and Scheduling

YCCO and delegates require participating providers to meet state standards for timely access to care and services considering the urgency of the member's need for services. Providers should have an after-hours call-in system adequate to triage urgent care and emergency calls from members.

- Calls should be returned appropriate to the member's condition, immediately if found to be emergent in nature, but in no event more than 60 minutes after receipt. If information is received to determine the call is urgent, the call shall be returned within 30 minutes in order to fully assess the nature of the call.
- All network provider's hours of operation are not fewer than the hours of operation offered to non-OHP members.
- Services included in the plan are available 24 hours a day, 7 days a week, when medically appropriate.
- Scheduling and rescheduling of member appointments are appropriate to the reason for, and urgency of the visit.
- Members shall be seen, treated, or referred within the following timeframes:
    - Physical Health:
    - Emergency care-Immediately or referred to an emergency department depending on the member's condition.
    - Urgent care-Within 72 hours or as indicated in initial screening, in accordance with OAR 410-141-3840 (telephone or face-to-face evaluation, capacity to conduct elements of an assessment, course of action at conclusion of assessment, provision for services and/or referral and provision for notification to other providers).
    - Well care-Within 4 weeks or within the community standard.
    - Oral Health:
    - Emergency oral care- Seen or treated within 24 hours.
    - Urgent oral care-Within one week or as indicated in initial screening in accordance with OAR 410-123-1060.
    - Routine oral care-Within an average of eight weeks and within 12 weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate.
    - Behavioral Health:
    - Urgent behavioral health treatment-Within 24 hours.
    - Non-Urgent behavioral health treatment- Seen for an intake assessment within 7 calendar days from date of request, with a second appointment occurring as clinically appropriate.

- In accordance with timeframes listed below for assessment and entry, terms defined in OAR 309-019-1015, with access prioritized per OAR 309-019-0135. In the event that timeframe cannot be met due to lack of capacity, member must be placed on a waitlist and provided interim services within 72 hours from being put on waitlist. Interim services must be comparable to original service request based on level of care and may include referrals, methadone, maintenance, HIV/AIDs testing, outpatient services for SUD, risk reduction, residential services from SUD, withdrawal management, and assessments or other services per OAR 309-019-0135.
- IV drug users including heroine must be provided with an immediate assessment and entry. Admission for treatment in residential level of care is required within 14 days of request, or if interim services are required due to capacity issues, admission must take place within 120 days from placement on a waitlist.
- Veterans and their families, pregnant women, women with children, unpaid caregivers, families, and children ages birth through 5, individuals with HIV/AIDS or Tuberculosis, individuals at risk for first episode psychosis and I/DD population must be provided with an immediate assessment and entry. If interim services are necessary due to capacity issues treatment at appropriate level of care must commence within 120 days from placement on a waitlist.
- Opioid use disorders; assessment and entry within 72 hours.
- Children with serious emotional disturbance defined per 410-141-3500; any limits the Authority may specify in contract or in sub regulatory guidance.
- Member requiring medication assisted treatment must be provided with an assessment and induction no more than 72 hours for assessment and entry, with efforts to provide care as soon as possible documented and consideration given to providing ICC services as applicable under OAR 410-141-3865-3870. Additionally, YCCO must also:
  - Assistance in navigating health care system and utilize community resources such as hospitals, peer support specialist, and the like as needed until assessment and induction can occur;
  - Ensure providers provide interim services daily until assessment and induction can occur and barriers to medication removed. Daily services may include using community resources. And in no event will YCCO or provider require member to follow a detox protocol as a condition of providing these members with assessment and induction;
  - Assessment will include a full physical as well as a bio-psycho-social spiritual assessment and prescribe and deliver any necessary medication taking into consideration the results of such assessment and the potential risks and harm to the member in light of the presentation and circumstances; and
  - Provide no less than 2 follow up appointments to such members within 1 week after the assessment and induction.

Providers must apply the same standards to their YCCO members (including hours of operation) as they do to their commercially insured or private pay patients. All appointment availability standards are required and may be monitored for adherence to the standards.

Non-Scheduled Walk-Ins

- Provider procedures for triaging walk-ins must include the following actions:

When a member walks in without an appointment, office staff record the member's demographic information (name, address, etc.) and presenting problem and send this information to the triage nurse or provider.

- The triage nurse or provider performs a preliminary assessment of the member's condition.
  - Members with **emergent** conditions are seen immediately and/or referred for transport to the nearest hospital.
  - Members with **urgent** conditions are seen within two hours, depending on the severity of the condition, and/or referred for transport to the nearest hospital.
  - Members who present with a non-urgent condition are scheduled for an appointment as medically appropriate.

YCCO Member Rights and Responsibilities

YCCO and all in-network providers, contractors and sub-contractors comply with any applicable federal and state laws that pertain to member rights. All are committed to observing and protecting those rights.

All YCCO OHP Members have the following rights and responsibilities-
Member Rights:

- Treatment with respect and with due consideration for their dignity and privacy and the same as non-members or other patients who receive services equivalent to covered services;
- Treatment by participating providers the same as other people seeking health care benefits to which they are entitled;
- Freedom to choose a coordinated care organization (CCO) as permitted, a primary care provider (PCP) or service site and to change those choices as permitted in OAR 410-141-3590;
- To refer themselves directly to mental health, chemical dependency, or family planning services without getting a referral from a PCP or other participating provider;
- To have a friend, family member, or advocate present during appointments and at other times as needed with clinical guidelines;
- To be actively involved in the development of the member's treatment plan;
- To be given information about the member's condition and covered and non-covered services to allow an informed decision about proposed treatments;
- To consent to treatment or refuse services and be told the consequences of that

decision, except for court ordered services;

- To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;
- To have written materials explained in a manner that is understandable to a member;
- To receive necessary and reasonable services to diagnose the presenting condition;
- To receive covered services under OHP that meet generally accepted standards of practice and is medically appropriate;
- To obtain covered preventative services;
- Access to urgent and emergency services 24 hours a day, seven days a week as described in OAR 410-141-3835
- Referrals to specialty providers for medically appropriate services;
- A clinical record maintained that documents conditions, services received, and referrals made;
- Access to one's own clinical record unless restricted by statute;
- To transfer a copy of the member's clinical record to another provider;
- Right to execute a statement of wishes for treatment including the right to accept or refuse medical, surgical, chemical dependency, or mental health treatment and the right to execute advance directive and powers of attorney for health care;
- To receive written notice before a denial of or change in a benefit or service level is made unless such notice is not required by federal or state regulations;
- Information on how to make a complaint or appeal with YCCO or request an administrative hearing with the Authority and receive a response per OAR 410-141-3875 - 410-141-3910;
- To exercise his/her/their rights without adverse treatment by the CCO, its network providers, or the State Medicaid agency.
- To receive interpreter services as defined in OAR 410-141-3515; and
- Timely appointment cancellation notices.
- Require, and cause YCCO in-network providers to require, that members receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language, and ability to understand.

Member Responsibilities:

- To choose or help with assignment to a CCO as defined in OAR 410-141-3500 and a PCP or service site;
- To treat the CCO, providers and clinic staff with respect;
- To be on time for appointments made with providers and to call in advance either to cancel if unable to keep the appointment or if the member expects to be late;
- Seek periodic health exams and preventative services from a PCP or clinic;
- Use of a PCP or clinic for diagnostic and other care except in case of an emergency;
- To obtain a referral to a specialist from their PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;
- Use of urgent and emergency services appropriately and notification to PCP within 72 hours of an emergency;
- Providing accurate information for inclusion in their clinical record;
- Assistance to the provider or clinic to obtain clinical records from other providers that may include signing an authorization for release of information;

- To ask questions about conditions, treatments, and other issues related to the member's care that is not understood;
- To use information to make informed decisions about treatment before it is given;
- Assist the provider in creation of a treatment plan;
- Follow prescribed agreed upon treatment plans;
- Advise the provider that the member's health care is covered under OHP before services are received and, if requested, to show the provider the OHP coverage identification form or card;
- Notification to OHA worker of a change of address or phone number;
- To tell the OHA worker if any family member becomes pregnant and notify the worker of the birth of the member's child;
- Notification to the OHA worker if any family members move in or out of the household;
- To tell the OHA worker if there is any other insurance available;
- Payment for non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;
- To pay the monthly OHP premium on time if a premium is required;
- Assistance to the CCO in pursuing any third-party resources available and to pay the CCO the amount of benefits it paid for any recovery received from that injury;
- To bring issues, complaints, or grievances to the attention of the CCO; and
- To sign an authorization for release of medical information so that OHA and the CCO can get information that is pertinent and needed to respond to an administrative hearing request in an effective efficient manner.

American Disabilities Act (ADA), Cultural Considerations & Non-Discrimination

YCCO promotes the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

YCCO including all partners, staff and network providers comply with applicable Federal civil rights laws and do not discriminate against, exclude, or treat people differently based on race, color, ethnicity, national origin, age, language, physical or mental disability, religion, sex, sexual orientation, and gender identity or expression.

All YCCO and partner network providers will provide effective, equitable, understandable, and respectful quality care and services, including, without limitation, free-of-charge certified or qualified oral and sign language interpreters to all members, and accessible health and healthcare services for individuals with disabilities in accordance with Title III of ADA. Including but not limited to physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities such as street level access or accessible ramp into the facility and wheelchair access to offices, exam room(s), restrooms, and equipment; providing

information in the manner in which the member understands including written materials in alternative formats, and interpretation.

Understanding the demographics of the population served and how those demographics are reflected in the staff and providers in the agency serving them is an important component of discrimination and equitable provision of service. Providers will be expected to collect REAL+D demographics (race, ethnicity, age, language, and disability) about their YCCO member population and staff according to REAL+D requirements of House Bill 2134.

YCCO participates in the state's efforts to promote delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Including but not limited to the following:

- Procedures for communicating with members who have difficulty communicating due to a medical condition or living in a household where there is no adult available to communicate in English or there is no telephone;
- Certified or qualified interpreter services by phone or in person;
- Coordinated care services which are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect on the member's care; and

Compliance with the requirements of the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Age Discrimination Act of 1975, Rehabilitation Act of 1973 and all amendments to those acts and all regulations declared thereunder.

YCCO will ensure that all YCCO staff, partners and network providers have implicit bias; structural barriers and systemic oppression; CLAS (culturally and linguistically appropriate services including language access, interpretation, and health literacy); Adverse Childhood Experiences and historical trauma; ADA and accessibility; and REAL+D (race, ethnicity, age, language, and disability) training.

Additional information on ADA and non-discrimination may be found in the YCCO Member Non-Discrimination/ADA Policy and Procedure.

Interpretation Services

All contracted providers must make interpretation services available to YCCO members. Interpretation must be available during and after hours for consultation and provision of care. Interpretation can be provided by certified or qualified staff, or by a certified or qualified interpretation service either on site or over the telephone. Interpretation should *not* be provided by a member of the patient's family or ad hoc interpreter.

Bilingual staff as Interpreters

Qualified staff must be designated by the provider office as an individual who will provide oral language or sign language assistance as part of the individual's current,

assigned job responsibilities and who has demonstrated to the provider's office that they are:

- Proficient is speaking and understanding both English and at least one other spoken language or sign language, including any necessary specialized vocabulary, terminology, and phraseology and
- Is able to effectively, accurately, and impartially communicate directly with individuals who use sign language or with limited English proficiency in their primary languages.

If the staff member does not meet the above criteria (example: interpretation is not part of the staff member's job duties) then the bilingual staff member can only provide interpretation services if there is an emergency involving imminent threat to the safety or welfare of an individual or public.

Passport To Languages

YCCO coordinates and pays for interpretation services for members' medical appointments for covered services through our preferred vendor, Passport to Languages (PTL). To arrange for an interpreter to be present during an appointment or for telephone interpretation you can call PTL at 503-297-2707or request services via the PTL their website http://www.passporttolanguages.com you must submit request at least **2 working days prior** to your appointment date. PTL's Customer Service staff sends a fax or email to the provider's office to confirm that interpreter arrangements are complete.

For urgent needs (fewer than 48 hours' notice), call PTL's Customer Service department at 503-297-2707 to arrange for an interpreter.

YCCO's vendor Passport to Languages does not offer the following services:
• Appointment reminders*
• Scheduling or rescheduling appointments*
• Relaying test results*
• Registration for procedures/admissions*
• Telephonic services less than 10 minutes in duration*

*These services must be provided by all providers in a culturally competent manner including providing to those with limited English proficiency. It is the responsibility of the clinic or provider to offer appropriate communication in the language the Member prefers at all points of contact and information sharing.

Advance Directives & Declaration of Mental Health Treatment

Members, under federal and Oregon law, have rights concerning their medical and mental health care, including the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive or declaration for mental health treatment. Providers are required to have written policies concerning these rights with implementation of the rights of members with a clear and precise statement of limitation per CFR 42 Subpart I 489.102 and OAR 410-141-3585. Advance Directives and

Declaration of Mental Health Treatment forms can be found on the following links:
https://www.oregon.gov/oha/PH/ABOUT/Documents/Advance-Directive.pdf
https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/le9550.pdf

Seclusion and Restraint

YCCO ensures members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation as specified in federal regulations on the use of restraints and seclusion.

Transportation for OHP Members

Non-Emergent Medical Transportation (NEMT)
NEMT program provides free-non-urgent rides, mileage reimbursement, and bus tickets (and in some cases bus passes) to covered appointments for YCCO members who have no other transportation options. Members can schedule rides:

- 90 days in advance
- For more than one service or those that reoccur up to 90 days in advance
- Same-day visits

Covered NEMT services are provided 24 hours a day, 365 days a year.

WellRide has afterhours Customer Service, call our toll-free telephone number if you need help after hours. There is a message in English and Spanish, explaining how to access alternative arrangements after hours. If you leave a message after hours and the message is clear and includes a valid phone number, we will respond to the next workday. WellRide will make attempts to contact you until they do or, if not able to reach you, a message will be left. Call Center staff document all efforts to return your call or respond to a message.

YCCO WellRide Contact & Availability Information

Toll-free: 844-256-5720 TTY/Oregon Relay Service: 711
Hours of operation: 7:30 a.m.-6 p.m., Monday-Friday
WellRide's call center is closed on New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and Christmas Day.

More information on NEMT services can be found in the YCCO NEMT Rider Guide available on the YCCO website.

Emergency Transportation

Emergency ground or air ambulance transportation, when medically necessary, is a member benefit. Transportation required to return a member to the service area to obtain continuing care after a medical emergency also is covered. The PCP should discuss appropriate use of ambulance transportation with the member during the initial visit in the context of member responsibility for proper use of emergency services.

Return transportation is considered Non-Emergency Medical Transportation, discussed above.

Traditional Health Workers & Community Programs

At Yamhill Community Care, we strive to make our community a great place to live in.
Traditional Health Workers (THWs) is an umbrella term for frontline public health workers who work in the community, clinic and/or hospital. They support individuals in a variety of ways to achieve better health. THWs walk alongside members connecting them with resources to address their unmet needs.

There are five types of THWs available to YCCO members:

- Community Health Workers (CHW): CHWs can help you in receiving the healthcare you need.
- Peer Support Specialists (PSS): PSS can give support, encouragement and help to those facing addictions and mental health issues.
- Peer Wellness Specialists (PWS): PWSs give support, encouragement and help to address physical and mental health needs.
- Personal Health Navigators (PHN): PHNs offer care coordination for members from within the health system.
- Birth Doulas: Doulas give companionship and personal, non-medical support to women and families throughout the pregnancy, childbirth, and post-partum experience.

YCCO's Community Health Hub has a group of people focused on finding members the services they need.

- Click here to download a form for referring your patient to these resources. Community Health Hub Referral Form

Below are some of the resources our Community Health Hub can direct members to:

- Community Health Workers: CHWs meet CCO members wherever they're at, working with them to navigate their care and access resources to successfully manage their own health and well-being.
- Persistent Pain Program (PPP): The PPP is an 8-week class combining pain management education and movement therapy.
- Diabetes Prevention Program: Yamhill Community Care offers the National Diabetes Prevention Program. Groups meet for 16 weekly sessions and six-monthly follow-up meetings with a trained lifestyle coach.
- Project ABLE: Project ABLE partners peer specialists with people who need support getting healthier, both mentally and physically.
- Provoking Hope: Provoking Hope utilizes peer support to help people, especially families, who have encountered difficulty with drug or alcohol use.

- SNACK Program: The Student Nutrition and Activity Clinic for Kids pairs Linfield College interns with children up to age 18 who work with them and their families to make healthy lifestyle changes.
- Health and Wellness Workshops: These workshops are peer-led and offer a space to learn about managing chronic conditions like diabetes, pain, asthma, and heart disease.
- Multi-Disciplinary Team: This team brings together as many members of a care team as possible, including doctors, caregivers, behaviorists, etc., to coordinate the needs and services of a member.

Member Grievance System

Assurances through the Grievance System

Members and/or Providers are assured the following through the grievance system:

- Grievances, complaints, appeals, and contested case hearings are kept confidential and have a timely and appropriate resolution.
- Written notice of any adverse benefit determinations is provided. These notices are referred to as a Notice of Action/Adverse Benefit Determination (NOADB or Notice).
- YCCO Members have access to a robust process for handling grievances, complaints, appeals, and contested case hearings regarding the services they receive from YCCO.
- Members, an authorized representative, or a provider with the written consent of the member may file a grievance at any time either orally or in writing on behalf of a member.
- Grievances may be filed directly with YCCO or with the Authority. If filed with the Authority it will be forwarded to YCCO promptly.
- YCCO ensures member grievances and appeals are processed in accordance with Oregon Administrative Rules (OAR) 410-141-3875 through 410-141-3915.
- YCCO does not delegate final adjudication of appeals.
- YCCO members are informed that they have a right to file a grievance, appeal or contested case hearing orally or in writing and may have a member representative of their choice. The member or member's representative may also withdraw an appeal or contested case hearing request at any time.
- A member, member's representative, a representative of a deceased member's estate, or a member's provider acting on behalf of and with written consent of the member may file a grievance or appeal and request a contested case hearing. No punitive action will be taken against any provider who files a grievance, appeal, request a contested case hearing or request expedited resolution of an appeal on behalf of a member.
- YCCO will include in each notice of resolution with the determination not found in favor of the member that they may present the grievance to OHP Client

Services Unit (CSU) toll free at 800-273-0557 or OHA's Ombudsman at 503-947-2346 or toll free at 877-642-0450.

- If YCCO fails to adhere to the notice and timing requirements in 42 CFR 438.408, the member is considered to have exhausted the CCO's appeal process. In this case, the member may initiate a contested case hearing.
- That YCCO, its delegates, subcontractors, and its participating providers may not:
    - Discourage member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
    - Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
    - Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.
- Safeguard the member's right to confidentiality of information about grievance or appeal, except where the sharing of information is allowed for the purposes of treatment, payment or health care operations as defined in 42 CFR 164.501. The following pertains to the release of the member's information:
    - YCCO and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal or hearing may use the information without the member's signed release for purposes of:
        - Resolving the matter; or
        - Maintaining the grievance or appeals log as specified in 42 CFR 438.416.
    - If YCCO needs to communicate with other individuals or entities not listed above to respond to the matter, YCCO will obtain the member's signed release and retain the release in the member's record.
- Safeguard member's anonymity for protection against retaliation in the member grievance and appeal resolution process.
- No incentivized compensation for utilization management activities by ensuring that individual(s) or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any member.
- Cooperate with the Department of Human Services Governor's Advocacy Office, the Authorities Ombudsman and hearing representatives in all activities related to member's appeals, hearing requests, and grievances including all requested written materials.
- Ensure members receive continuing benefits when requested and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending.
- All written grievance system information will be provided with the following guidelines:
    - Easily understood language and format;
    - Font size no smaller than 12 point;

- Be available in alternative formats and through the provisions of auxiliary aids and services in an appropriate manner that takes into consideration with special needs of enrollees or potential enrollees with disabilities or limited English proficiency;
- Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font no smaller than 18 point.

YCCO will not take punitive action against any provider who requests an expedited (fast) resolution or supports a member's grievance or appeal.

Grievance System Process, Policy and Rights Awareness and Sharing

As a contracted provider, delegate and/or subcontractor you are responsible for ensuring Members have access to grievance, appeal and contested case hearing processes and be aware of procedures and timeframes. Including:

- The member's right to a contested case hearing, how to obtain a hearing and representation rules at a hearing;
- Member's right to file grievances and appeals with the requirements and timeframes for filing;
- The availability of assistance to members with filing of grievances, appeals and contested case hearings, toll-free numbers to file oral grievances and appeals;
- Member right to continuation of benefits during the appeal and contested case hearing processes and if the action is upheld in a contested case hearing, the member may be liable for the cost of any continued benefits; and
- The provider appeal rights to challenge the failure of YCCO to cover a service.

When a provider files an appeal on behalf of a member, the provider may subsequently request a contested case hearing on behalf of the member in accordance with the procedures in OAR 410-141-3900-3905.

YCCO's approved written Grievance System policy and procedures are provided to ensure compliance at the time of contract. A copy is added to this handbook. Please note policies are subject to change when changes take place with the OHA CCO Contract or through Oregon and Federal Law. These policies will be updated as appropriate, contact YCCO to insure you have the most recent version. For more information on this system, Members and Providers can contact Customer Service at 1-855-722-8205 for assistance.

Grievance System Time Frame Filing & Resolution Standards

Category	Timeframes		Possible Extension	Notices
	Days for YCCO Action	Days for Member to File		
Grievance	5 business days or Expeditiously as the member's condition allows.	Any time	Up to 30 days	Resolution letter within 5 business days. Written delay notification within 5 business days from receipt with an explanation for the reason of the delay. Resolution letter within 30 days of receipt when delayed.
Standard Appeals	16 days or Expeditiously as the member's condition allows.	60 days from date of the Notice of Adverse benefit determination	Up to 14 days if member request extension or the need for additional information and how the delay is in the best interest of the member (this delay must meet the satisfaction of OHA and be shown upon its request)	Acknowledgement or resolution within 5 business days; NOAR within 16 days; Extension notification within 2 days (with reasonable effort of oral notification). If extension given NOAR within 30 days
Expedited Appeals	72 hours	60 days from date of the Adverse benefit determination	Up to 14 days if member request extension or the need for additional information and how the delay is in the best interest of the member (this delay must meet the satisfaction of OHA and be shown upon its request)	Acknowledgement of receipt orally and in writing within 1 business day. NOAR 72 hours or orally as soon as possible. If extension notification within 2 days If extension NOAR within 14 days
Standard Contested Case Hearing	90 days from date the member files appeal 2 business	120 days from date of YCCO appeal resolution	None	Final Order within 90 days

	days to submit to the Authority all records from appeal			
Expedited Contested Case Hearing	2 business days to submit to the Authority all records from appeal	120 days from date of YCCO appeal resolution		Final Order within 2 business days, if expedited hearing is declined. As expeditiously as member's health condition requires with typical limits from 3 to 7 days for completions, oral notification as soon as possible

Provider Rights and Responsibilities

All obligations of the Participating Practitioner Agreement, general principles, responsibilities, and procedural protocol set forth in the preceding sections of the manual apply when serving YCCO members.

In addition, YCCO is required to meet contract requirements specified by the Oregon Health Authority (OHA) for Coordinated Care Organizations. The delivery of medical services to YCCO members must conform to OHA policies, procedures, rules, and interpretations in the following order of precedence:

1) Federal law, regulation and waivers granted OHA by CMS to operate the Oregon Health Plan;
2) Oregon state law;
3) Oregon Administrative Rules and OHA General Rules;
4) Any other duly promulgated rules issued by OHA and other offices and divisions within the Department of Human Resources necessary to administer the OHP.

OHA furnishes individually enrolled OHA providers with the OHA Provider's Handbook for Medical-Surgical Services and the CMS-1500 Billing Guide and any current OHA Service Guide(s) specific to the provider's category of service. The documents establish service and billing procedures and are to be used in conjunction with the current OHA General Rules and Oregon Health Plan Administrative Rules. To order OHA forms/publications and to determine OHA provider enrollment status, go to the OHA website.

Providers have the right to:

- Receive information from the Health Plan regarding treatment and utilization patterns for the members they serve and know how they as providers compare with their peers.

- Disagree with Health Plan review and/or decisions that affect the treatment or care of members, or that endangers their professional standing as participating providers, and be heard through a formal appeal process.
- Be reviewed and evaluated by a panel of their peers on issues of clinical practice.
- Be treated courteously by Health Plan members.
- Be supported by the Health Plan in educating members about their responsibilities.
- Expect prudent and responsible fiscal management of Health Plan business.
- Expect prudent and responsible fees for provider services.
- Have timely and accurate adjudication of claims for services rendered.
- Receive timely payment from the Health Plan.
- Be informed of Health Plan administrative rules, policies, and standards of practice.
- Not be discriminated against based on provider's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed, or patients in whom provider specializes.

Providers have the responsibility to:

- Provide competent, compassionate, and individualized quality care to Health Plan members within the scope of their practice and profession.
- Provide care in a manner that is respectful and considerate of the members' unique needs.
- Be knowledgeable of the Health Plan's administrative rules, policies, and standards of practice.
- Be informed of member rights and responsibilities and respect these rights and responsibilities.
- Provide information so that a member can give informed consent for member treatment. Fully disclose to the member treatment options not covered by the Plan that may be of benefit to the member. Obtain consent from an appropriate surrogate if the member is unable to participate in decision-making.
- Give priority to clinical and scientific considerations over financial considerations.
- Adhere to the Health Plan's Clinical Practice Guidelines or, where the provider judges the standards not to be in an individual member interest, advocate another treatment option to the Plan.
- Work with YCCO to meet Transition of Care requirements per OAR 410-141-3850 for Oregon Health Plan Members.
- To participate in a timely manner with the Plan assuring all relevant information in the Provider Directory is accurate.
- To annually attend Cultural Responsiveness and implicit bias training and retain records the training was completed. The training should also be provided to the Provider staff. OHA pre-approved training to meet this obligation can be accessed on OHA's website located at: https://www.oregon.gov/oha/OEI/Documents/CCCE%20Registry_041919.pdf
- Encourage and assist members to make advance directives and assure that directives are honored to within the confines of state law.

- Educate and encourage members to maintain health and to use preventive and early- intervention services.
- Keep confidential all communications and records related to care, except in the case of persons who have a need to know because they are participating in the delivery of care, in Medical Management and Quality Management activities, or in resolution of claims or grievances.
- Maintain confidentiality of information about individual members. Provide information to employers only when permission of the member is obtained. Follow federal and state privacy regulations, including maintaining an Accounting for Disclosures database which tells members if their health information has been disclosed inappropriately as required by federal and state regulations.
- Be courteous when discussing Health Plan policy or procedures with Plan employees or representatives.
- Pursue continuing medical education.
- Issue denial notices or notify the Health Plan of a denial, when either a service or referral is not approved.
- Bill and Appeal within timely filing.
- Bill electronically whenever possible.
- Educate and encourage members to use the Plan's resources prudently.
- Utilize appropriately the resources allocated by the Plan.
- Treat members without regard to the provider's financial gain or loss when the treatment is appropriate and necessary.
- Participate in the collection of outcome data and quality assurance data.
- Speak out and resist if peers, purchasers, or the Plan is pursuing unethical practices.
- Protect patient rights while maintaining a professional approach in discussing the Plans policies and procedures.
- Abide by policies and procedures of the Plan that are a result of collaborative deliberation of the Plan and its physician leadership.

Provider Relations

YCCO Provider Customer Service can assist you in the following ways:

- Provide YCCO policies and procedure information to office staff.
- Provide education to office staff to gain access to PH Tech CIM3 portal.
- Answer questions about your Participating Practitioner Agreement and clarify information contained in this manual.
- Act as your liaison for other Health Plan issues.

Contact YCCO Provider Customer Service at 855-722-8205 for information about Provider Relations. You can also send an email to providerrelations@yamhillcco.org.

CIM3-The YCCO Provider Portal

CIM3 is the portal used by the YCCO network. If you do not have access to CIM contact Provider Customer Service at 855-722-8205.

. Use CIM3 to:

- Verify patient benefits
- View patient roster
- Access medical policies
- Submit referrals and prior authorizations
- View existing referrals
- Get claims information
- Get explanation of payment (EOP)
- See PCP Quality Reports
- Read newsletters
- Stay updated

You may have additional provider portals to access provider information and tools based on your provider type and the services you provide. Provider Customer Service can assist you with this information.

Credentialing & Contracting

YCCO and Delegated Partners follow all OHA CCO Contract, State and Federal Rules and has guidelines for all aspects of the credentialing and re-credentialing process, including appropriate verifications, SAM & OIG screenings, credentialing decisions, adverse actions, process timeframes and notifications. YCCO will ensure that all practitioners/providers have the legal authority and appropriate training, certification, license, and experience to provide care to members prior to participation with the coordinated care organization and that the process will be followed for all licensures and by any entities that perform the process on YCCO's request or behalf. The YCCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The YCCO QA-002 Credentialing Process Policy and Procedure provides additional information pertaining to YCCO credentialing.

Credentialing and contracting may be a delegated function and held by one of our delegated partners, below is a list of the partners, their contact information, and the provider types they work with.

Physical Health
Telephone: 503-488-2800

Oral Health
Telephone: 503-585-5205
Email: Providers@capitoldentalcare.com

Behavioral Health

Telephone: 503-474-6884
Email: yccocredentialing@co.yamhill.or.us

Non-Emergent Medical Transportation
Telephone: 844-256-5720

Once a provider has met all requirements for network participation and a contract is issued and signed the provider will receive the appropriate Delegated Partner Provider Manual/Handbook as well as the YCCO Provider Handbook.

Performance Monitoring

The reappraisal process includes the following components, as available, which are reviewed as part of the recredentialing profile at least every three years:

- Profiles on the utilization of resources.
- Adverse outcomes/sentinel event cases.
- Member complaints.
- Access and site visit audit results.
- Medical record documentation audit results.
- Quality Bonus/Preventive Health Measure rates.

Data is compared to the thresholds as established by the CQC. If the practitioner exceeds any threshold, the practitioner will be referred to the CQC for review and recommendation. Practitioner Performance Reviews that result in the recommendation of probation or other disciplinary process will be implemented per policy and tracked by the Quality and Medical Management Department and the CQC.

Covering Providers and On-Call Arrangements

YCCO and delegates require participating providers to meet state standards for timely access to care and services considering the urgency of the member's need for services. Providers should have an after-hours call-in system adequate to triage urgent care and emergency calls from members. It is essential that members be able to reach the PCP/PP or on-call practitioner at any time. The provider must have a system in place that allows a patient to be evaluated telephonically by a live person. The evaluator will be able to give the patient clinical advice or to facilitate contact with another individual who has that ability. Additional information related to appointments is located under the Availability of Appointments and Scheduling section.

Communication Among Providers/Care Coordination

In the interest of providing quality and efficient patient care, practitioners should communicate the results of any treatment, including the annual gynecological exam to the members PCP/PP. This allows the PCP/PP to maintain complete patient records and fulfill the responsibilities of care coordination and consultation. Each member has a PCP or primary care team that is responsible for coordination of care and transitions.

YCCO coordinates physical health, oral health, behavioral health, intellectual and developmental disability, and ancillary services, between settings of care including appropriate discharge planning for short and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities.

- Behavioral health providers will explain to members the importance of collaborating behavioral health services w/PCP, dentists, or previous behavioral providers.
- With services members receive from other coordinated care organizations, fee-for-service Medicaid, the community, and social support providers.

Filing Claims

YCCO will be billed for all services provided to Health Plan members regardless of primary or secondary diagnosis position. All bills for service to YCCO members should be submitted directly to YCCO. Members should only receive a bill or statement when there is a patient responsibility portion remaining after YCCO payment and a signed waiver form (OHP Client Agreement to Pay for Health Services OHP 3165).

Claims for YCCO members should be submitted electronically whenever possible.

Paper claims can be mailed to:
Yamhill Community Care Claims
PO Box 5490
Salem OR 97304

YCCO accepts electronic claims through various vendors. For more information, contact your Provider Relations Representative or YCCO Customer Service

Information Required for Filing Claims
To ensure timely claims processing, all claims must be submitted on a CMS 1500 form (formerly a HCFA 1500 form); or, for facilities, on a UB-92 form. Information on the claim form must be printed in black ink with a standard 10- or 12-point type face. Place required information only in the appropriate field and be sure to align the form so that each item is properly located within the box.

The list below includes general categories of information necessary for claims processing. If any of this information is missing from your claim, it could be delayed or returned to you.

1. Patient's full name and date of birth.
2. Patient's PHP/PHA member number (including the identifying suffix).
3. Subscriber's full name and relationship to patient.
4. Group number or name.
5. Information about other insurance coverage.
6. ICD-10 CM codes (code to the highest level of specificity).
7. Description of any accident circumstances.
8. CPT or HCPCS codes for services performed (use current year codes).
9. Place service codes per CMS guidelines (use list effective 8/01 available on the CMS website).
10. Itemized changes, by date of service (only one service per line).

11. Provider’s name, UPIN #, TIN# and financial address (Box 33)
12. Name and address of facility where services where rendered (Box 32 on HCFA)

Overpayment

YCCO is committed to ensuring the appropriate adjudication of claims. However, when overpayments of claims occur, YCCO will recover the overpayment in the most efficient and cost effective way for YCCO and the provider.

YCCO has a mechanism in-place for network providers to report receipt of an overpayment. The provider is required to notify the plan and return the full amount of the overpayment within 60 calendar days after the date on which the overpayment was identified and provide in writing the reason for the overpayment. In the event YCCO makes an overpayment to a provider, YCCO will recover the full amount of the overpayment from the provider.

Coordination of Benefits

When a member is eligible for more than one health plan at the same time, the health plans coordinate their payments to avoid overpayment of claims. YCCO and the OHA collects information about other insurance coverage that members may have. If our records indicate that a member has a primary insurance other than YCCO, we must receive a copy of the Explanation of Payment Benefits (EOB) from the primary carrier with your billing. Members should not receive a bill for remaining balances unless the services were not a covered benefit or until both the primary and secondary have processed and paid the claim. If you are unsure of primary coverage, please call customer service.

Third Party Liability

If the diagnosis or treatment on a billing suggests that a third party may be liable for the charges, we will investigate this prior to claims payment. Please provide accident information with your billing.

Timely Claims Submission

Claims must be submitted on a timely basis. OHA requires that providers submit all claims within 120 days (4 months) of the date of service. The member **cannot** be billed for these services if the provider does not file timely. We may choose to waive the timely filing rule for Medicaid if a claim meets one of the following criteria and proof is submitted:

- Newborns
- Medicare coverage
- Other insurance coverage
- Maternity-related expenses
- Claims denied by Workers’ Compensation
- Claims processed or adjusted after retroactive eligibility changes

If a Provider disagrees with the way a claim was paid, YCCO must be notified within 180 days of payment or denial of the claim.

Billing a Member

OHP/YCCO does not collect co-payments for services provided to our members. Providers are prohibited from billing a YCCO member for Medicaid covered services.

Members may only be billed if **all** of the following criteria are met:

- The service is not covered by Medicaid.
- All reasonable covered treatments have been tried or member is aware of reasonable covered treatments, but selects a treatment that is not covered; and
- Member and provider have completed an OHP Client Agreement to Pay for Health Services form (OHP 3165).

The OHP Client Agreement to Pay for Health Services form (OHP 3165) can be found on the OHA website at:
https://www.oregon.gov/oha/HSD/OHP/Pages/Providers.aspx
If the client accepts financial responsibility for a non-covered service, payment is a matter between the provider and the client subject to the requirements of OAR 410-120-1280.

Discharge and Disenrollment of Members

Definitions

- **Discharge**: A member is removed from the care of their assigned PCP.
- **Disenrollment**: A member is removed from their health plan.
- **Verbal abuse**: Abusive language that contains a menacing tone with the intent of threat and is often accompanied by physical and language clues.

Requirements

Although there are general Oregon Health Authority (OHA) guidelines for discharging a member from a PCP, YCCO is responsible for establishing specific discharge policies and procedures. YCCO must follow the guidelines established by the OHA regarding disenrolling members from the plan.

YCCO's philosophy is to encourage members and their providers to resolve complaints, problems, and concerns at the clinic level. However, before discharging a member or requesting that a member be disenrolled from YCCO, the PCP must request YCCO's involvement to help resolve the problem or concern.

If clinic management decides to discharge the member, a letter must be sent to the member informing him/her/them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address, and client number. Fax a copy of the discharge letter to 503-376-7436 Attn: Enrollment Department. If any of the above information is missing, the discharge may not be processed and additional actions may be required.

IMPORTANT: PCPs are asked to provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

Just Causes for Discharging a Member
A member may be discharged from a PCP or disenrolled from YCCO only with just cause. Just causes identified by OHA include but are not limited to the following:
• Missed appointments (except prenatal care patients)
• Drug-seeking behavior
• The member commits or threatens an act of physical violence directed at a medical provider or property, clinic or office staff, other patients or YCCO staff
• Verbal abuse
• Discharge from PCP by mutual agreement between the member and the provider
• Agreement by the provider and YCCO that adequate, safe, and effective care can no longer be provided
• Fraudulent or illegal acts committed by a member, such as permitting someone else to use their medical ID card, altering a prescription, or committing theft or another criminal act on any provider's premises.

When a Member *Cannot* Be Discharged
According to OHA Administrative Rule 410-141-3800-3810, members cannot be discharged from a PCP or disenrolled from YCCO solely because of any of the following reasons:
• The member has a physical or mental disability.
• The member has an adverse change in health.
• The PCP or YCCO believes the member's utilization of services is either excessive or lacking, or the member's use of plan resources is excessive.
• The member requests a hearing.
• The member exercises their option to make decisions regarding their medical care and the provider/plan disagree with the member's decisions

Key Factors When Considering Discharging a Member
In general, the key requisites when considering discharging a member include:
• Timely, early communication and collaboration with YCCO staff to problem solve
• Thorough documentation of events, problems, and behaviors
• A plan generated by the PCP to attempt to address the problem or concerns
• YCCO strongly encourages using contracts and case conferences to address problems and concerns. (Call YCCO for sample contracts and assistance.)
• Consider mental health diagnoses as part of the discharge and disenrollment process.

Prioritized List of Health Services

The OHP covers a comprehensive set of medical services defined by a list of close to 700 diagnoses and treatment pairs that are prioritized and ranked by the Oregon Health Services Commission. This list is called the Prioritized List of Health Services. The state legislature determines funding levels for OHP benefits. To determine if a service is covered by YCCO, check the prioritized list on OHA's website at the following link:
https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx

The line on the prioritized list determines whether or not a treatment is covered by the OHP.
• Diagnosis and treatment pairs that fall **above the line** are generally covered by the OHP
and YCCO.
• Diagnosis and treatment pairs that rank **below the line** are not generally covered benefits of either the OHP or YCCO.

The list can also be accessed by calling DMAP Provider Services at 1-800-336-6016. If a service is not covered by the OHP and a provider decides that treatment is essential, an authorization request may be submitted with relevant documentation to the Prior Authorization department.

Covered services for OHP members may include, but are not limited to,

- Provider/physician services
- Outpatient hospital
- Inpatient hospital
- Prescription drugs
- Hospice
- ER transportation/ambulance
- Hearing aids, batteries, services
- Durable Medical Equipment and Supplies
- Home Health/private duty nursing
- Physical therapy/occupational therapy
- Speech/language pathology
- Vision exams, therapy, and materials
- Chemical dependency services
- Family planning services
- Non-Emergency Medical Transportation (NEMT)
- Mental Health Services
- Dental Services
- Care Coordination and Intensive Case Management Services

*Some of these services are administered directly by YCCO, YCHHS for behavioral health, or Capitol Dental Care for oral health. Contact information is located on the YCCO member ID card.

Current condition/treatment pairs on the Prioritized List of Health Services can be found on OHA's website. https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Prioritized-List.aspx

The PCP has responsibility for the management of the member's health care needs. OHA describes non-covered conditions/treatments to Oregon Health Plan clients as "services that get better without treatment, diseases or conditions for which there is no useful treatment, or treatment that is just cosmetic."

Diagnostic services, which are necessary and reasonable to diagnose the presenting condition, are covered regardless of the placement of the condition on the list. Also covered are one-time referrals for diagnostic clarifications and treatment planning. Please note that the member will likely not be able to see that provider again (unless diagnostic clarification makes it appropriate to do so), so treatment planning recommendations made during that visit should be considered for implementation by the referring PCP.

YCCO may, on a case-by-case basis, elect to approve for coverage therapeutic services for those conditions that fall below the line. The following criteria must be met in order for the Plan to consider the request:

1. The condition severely incapacitates the individual, preventing or interfering with function and proposed therapy will significantly improve the condition.
2. Lack of therapeutic treatment will result in deterioration of the condition, which will then require more costly and involved medical care.
3. Patient has a co-occurring diagnosis that is paired with the requested treatment on the prioritized list.

The request for coverage (a benefit exception) must be made in writing and must include documentation of the above as well as all pertinent medical information. The request should be directed to the Preauthorization Department. As medical information will be required, a telephone request will not be adequate to initiate the review.

Covered services are provided in no less than the amount, duration, and scope of the same services to beneficiaries under fee-for-service Medicaid, as set forth in 42 CFR 440.230 and for members under the age of 21, as set forth in 42 CFR 441 subpart B. YCCO ensures:

1. Services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
2. Does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

Excluded Services and Limitations

Certain services or items are not covered under any program or for any group of eligible clients. Service limitations are subject to the Health Evidenced Review Commission (HERC) Prioritized List of Health Services as referenced in 410-141-3830 and the individual program chapter 410 OARs. Information on these services is also located in OAR 410-120-1200.

YCCO places or may place appropriate limits on a service:

1. On the basis of medical necessity criteria.
2. For the purpose of utilization control, provided that:
    a. Services furnished can reasonably achieve their purpose.
    b. Services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member’s ongoing need for such services and supports.
    c. Family planning services are provided in a manner that protects and enables the member’s freedom to choose the method of family planning to be used consistent with contractual requirements.

Clinical Practice Guidelines

YCCO, through its Quality Committee reviews and adopts practice guidelines that define standards of practice as they pertain to improving health care quality for major disease/diagnoses.

Physical health practice guidelines are posted at the following link:
https://www.providencehealthplan.com/providers/medical-policy--rx-pharmacy-and-provider-information#C194B2D2B5A146F2B5C432018D3CFC41
Behavioral health practice guidelines are posted at the following link:
https://yamhillcco.org/wp-content/uploads/YCCO-MH-Levels-of-Care-Model-7.27.16.pdf
Dental Health practice guidelines are posted at the following link:
http://capitoldentalcare.com/providers/practice-guidelines/

Paper copies of these guidelines are available upon request, contact customer service to request a copy.

Services Covered by OHP Fee-For-Service

Some services are covered by OHP Fee-for- Service but are not covered by YCCO. For more information on these services call OHP Customer Service at 800-699-9075.There are two types of benefits OHP covers but YCCO does not. They are: Noncovered services without care coordination and non-covered services with care coordination.
Non-covered services without care coordination are:

- Physician-assisted suicide under the Oregon Death with Dignity Act
- Hospice services for member who live in a skilled nursing facility
- School-based health services that are covered services paid with the educational services program
- Administrative exams to find client eligibility for an assistance programs or casework planning
- Services provided to Citizen/Alien Waived Emergency Medical members or CAWEM Plus-CHIP Prenatal Coverage for CAWEM
- Abortions Contact KEPRO Care Coordination Team at (800) 562-4620 for more info and assistance with these services

Non-covered services with care coordination are:

- Out-of-hospital birth (OOHB) services including prenatal and postpartum care for women meeting the required criteria
- Long term services and supports (LTSS) excluded from CCO's reimbursement
- Helping members to get access to certain behavioral health services. Some examples of these services are:
  - Certain drugs for some behavioral health condition
  - Therapeutic group home reimbursement for members under 21 years old
  - Long term psychiatric care for members 18 years old and older
  - Personal care in adult foster homes for members 18 years and older.

YCCO does provide NEMT rides for non-covered services with care coordination. Care Management can help you with setting up a ride you can call them at 503-574-7247. You can also call YCCO WellRide at 844-256-5720 to set up a ride. NEMT rides are at no cost to the member.

Tobacco Cessation

YCCO pays for medications and telephone counseling with a trained coach to help members stop using tobacco products. If you have a member that uses tobacco products, you can provide Quit for Life, toll-free at 866-784-8454 (866-QUIT-4-LIFE) information.

Prior Authorization

Prior authorization is designed to help ensure medically appropriate services are ordered, assess potential member risk with treatment plans, and assist in containing costs. This can include review of certain medications, assessing the need for facility admission and the appropriateness of the proposed level of care before the admission occurs. This also provides an opportunity to initiate care coordination and pre-admission discharge planning. Please refer to CIM3 for the most up to date Prior Authorization lists.

Second Opinion

A second opinion is performed by an independent clinician and may be requested by a member or provider. Members do not need authorization to seek a second opinion from an in-network YCCO provider. If a member wants a second opinion from an out of network provider YCCO approval is required. Second opinions are provided at no cost to the member.

There are times when a YCCO Medical Director may request an external review when clinical indications are not clearly established, or to gather information when the indications for a procedure or treatment do not clearly meet criteria.

Privacy and confidentiality of their medical records and personal information.

Members have the right to talk with health care providers in private, and to have all communications about their care and all information in their medical records kept confidential. In addition, any personal information that a member gives when they enroll in this plan is protected and will remain confidential. The Plan will make sure that unauthorized individuals cannot see or change anything related to member records.

- The Plan must get written permission from a member, or from their legally appointed representative, before giving medical information to anyone who is not directly providing their care or responsible for paying for members care, except for purposes that are specifically permitted by State and Federal laws or requirements (such as for use by programs that review medical records to monitor quality of care or to combat fraud and abuse).
- Members have the right to look at, or get a copy of, their medical records or have their medical records transferred to another provider. The member must be informed they may be charged a fee for copying their records.
- Members have the right to ask for changes and/or addendums to their medical record. In this instance the provider and plan would work together to decide if changes should be made.
- Members have the right to know how their health information has been shared with others inappropriately as required by federal and state regulations.

Pharmacy Program

Pharmacy Utilization Management Program
This program, in collaboration with the Oregon Regional Pharmacy and Therapeutics Committee, monitors plan-wide drug utilization trends and implements procedures to improve the quality, safety, clinical efficacy and cost-effectiveness of drug therapy for Health Plan members. This program is used to evaluate inappropriate prescribing or utilization practices; monitor and profile pharmacy provider dispensing patterns; and develops educational materials to inform prescribing providers of the relative efficacy and costs of various drug therapy alternatives.

A Pharmacy Prior Authorization Form and Pharmacy Medical Policy and Criteria are available upon request via CIM3 or the YCCO website www.yamhillcco.org. All covered outpatient drug authorization decisions received notices per section 1927(d)(5)(A) of the Social Security Act. Response is provided by telephone or other telecommunication device within 24 hours of a request for prior authorization.

The YCCO Formulary can be accessed on the YCCO website:
https://yamhillcco.org/providers/pharmacy/

Care Management

Care Management offers a systematic process of assessment, coordination, and intervention in response to a member's care coordination or case management needs. A Standard for Care Management Intervention is available upon request.

Although all populations are at times at risk for suffering from debilitating illness or injury, the YCCO population is particularly vulnerable. Care Management assessment is a critical resource. Care Management staff consists of Registered Nurses (RN), Medical Social Workers (MSW), Clinical Support Coordinators (CSC), and Behavioral Health Case Managers. Their services are available to support each provider in the endeavor to identify high-risk members and quickly address health care needs. Care Management's team can provide a plan of care for chronic, medically fragile, or high utilizing patients. Additionally, Care Management can assist members in finding emergency housing, out-of-home placements (foster home, ICF, SNF, etc.), crisis management and access to specialized clinical resources, as well as community resources.

Managing patients complicated or challenging health care needs requires teamwork to cost-effectively deliver high quality care. The content of the care plan is the responsibility of the attending provider in collaboration with consulting providers. Clinically specialized nurses, with oversight from physician advisors, will work closely with the PCP/PP to facilitate coordinated health care management. Care management can assist providers with developing and implementing a patient care plan.

Care Management services may be initiated through direct referral by calling Care Management at 503-574-6428 or via email at caremanagement@providence.org,

Intensive Care Coordination Services

Members may have special needs Intensive Care Coordination (ICC) will ensure that these needs are met.

YCCO will make ICC services available during regular business hours. Please call 503-574-6428 to reach an Intensive Care Coordinator.

ICC services include:

1) Early identification of members with disabilities or special needs.
2) Ensuring that providers consider the unique needs of such patients in treatment planning.
3) Helping medical providers coordinate services.
4) Helping providers link with community support and social services for patients with special needs.
5) Representing people with special needs in Providence Health Plan's internal quality assurance and dispute resolution processes.
6) Identifying and helping remove barriers to necessary covered care.
7) Documenting members' unique needs and steps taken to meet them.
8) Coordinate care with State and/or county caseworkers as appropriate.

ICC services will be available to assist medical providers to coordinate the care of members with special needs and to keep members, providers, and others from having to make numerous calls to meet these needs.

YCCO, YCCO contractors and subcontractors are available to provide information about ICC and other support services available for members. Any available training regarding ICC is provided to patient-centered primary care homes and other primary care staff multiple times a year. For more information you can call a Care Coordinator or YCCO Customer Service.

Fraud Waste and Abuse

Yamhill Community Care takes fraud, waste, and abuse (FWA) very seriously, and is committed to conducting its business in a lawful and ethical manner which includes prevention of FWA. YCCO complies with all state and federal laws and regulations pertinent to fraud, waste, and abuse, including without limitation, the State and Federal False Claims Acts, Anti-Kickback Statute, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). All potential violations are investigated and resolved. Reports about FWA can be made anonymously and reporters are protected under the applicable Whistleblower laws. More information about the YCCO FWA Prevention and Compliance Plan or to request a copy of the plan or policies pertinent to FWA contact YCCO Customer Service or by email info@yamhillcco.org.

Examples of FWA include but are not limited to:

- Someone using another person's insurance coverage for services.
- A provider billing multiple times for one service, billing for a more costly service than performed, or charging a member for a service they did not perform.
- A Provider ordering excessive or inappropriate tests, prescribing medications that are not medically necessary, or falsifying a diagnosis.
- A patient obtaining medications or products that are not needed and selling them on the black market or doctor shopping to obtain more medications.

- An insurer misleading enrollees about health plan benefits or denying valid claims.
- Undervaluing the amount owed by the insurer to a health care provider under the terms of its contract.

If you suspect fraud, waste, or abuse you can make a report a few ways:

Call the Hotline at 844-989-2845
Submit a report online at http://yamhillcco.ethicspoint.com/ or
Write to **Yamhill Community Care**
C/O Compliance Officer
807 NE Third St
McMinnville, OR 97128

You can also report fraud, waste, and abuse directly to the Oregon Department of Human Services. Call or write to the following to make a report:

To report member fraud call or write to:
DHS/OHA Fraud Investigation
P.O. Box 14150
Salem, OR 97309
Hotline: 1-888-FRAUD1 (888-372-8301)
Fax: 503-373-1525 Attn: Hotline

To report provider fraud call or write to:
Provider Audit Unit
P.O. Box 14152
3406 Cherry Avenue N.E.
Salem, OR 97309-9965
Hotline: 1-888-FRAUD1 (888-372-8301)
Fax: 503-378-2577

Or

Medicaid Fraud Control Unit (MFCU)
Oregon Department of Justice
100 SW Market Street
Portland, OR 97201
Phone: 971-673-1880
Fax: 971-673-1890

To report client and provider fraud online:
https://www.oregon.gov/dhs/abuse/Pages/fraud-reporting.aspx

YCCO Policies & Procedures:

Please note policies are subject to change when changes take place with the OHA CCO Contract or through Oregon and Federal Law, these policies will be updated as appropriate. Contact YCCO to ensure you have the most recent version.

If you have any questions regarding a YCCO Policy and Procedure, please contact YCCO Customer Service at 855-722-8205 or via email at info@yamhillcco.org.

Log of Revision/Review

Date	Revision/Review	By Whom
12/04/2019	Grievance System Time Frame Grid	JRoe, QA Specialist
07/08/2020	Policy Updates	JRoe, QA Specialist
02/12/2021	Additional contact information to report FWA and examples of FWA.	JRoe, Benefit Administration Supervisor

Appendix A

Discharging a Member

Follow these procedures to discharge a member from a PCP.

Process For Discharging A Member	
MISSED APPOINTMENTS	
RESPONSIBILITY	**ACTION**
PCP or PCP Staff	1. If a member misses an appointment, consider sending a letter to the member emphasizing the importance and expectation of keeping appointments and the expectation of advanced notice of cancellation. 2. If a member misses two appointments in a row after the initial office visit or three appointments over a six-month period, send a letter informing the patient that he/she/they must contact the clinic manager or other designated staff person before the member can receive further care. 3. Meet with the member. Ask the member to sign a completed contract outlining that he/she/they must contact the clinic manager or other designated staff person. 4. Fax a copy of the signed contract to the member's caseworker. 5. If the clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address, and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. **IMPORTANT**: PCPs are asked to provide urgent care for the discharged member for 30 days after the member is notified of the discharge. 6. Send relevant documentation to YCCO Provider Services, including chart notes, copies of letter(s) sent to the member, signed contracts, and/or documentation of case conferences. Fax a copy of the discharge letter to 503-376-7436, Attn: Enrollment Department.

Process For Discharging A Member

YCCO Care Coordinator	7. Work with YCCO Customer Service to assign the member to a new PCP.

DRUG-SEEKING BEHAVIOR	
RESPONSIBILITY	**ACTION**
PCP or PCP Staff	1. Meet with the member to develop a plan to address possible drug-seeking behavior and document meeting. Consider chemical dependency treatment.
YCCO Pharmacy Staff	2. At the PCP's request, restrict the member to one or more designated pharmacies and/or one or more designated prescribers.
PCP or PCP Staff	3. Document any contract violation in member's medical record. If the provider cannot manage the member's care, try to find another provider within the primary care clinic to manage the member's care. If another provider is not available within that clinic and clinic management decides to discharge the member: Send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address, and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. AND Fax a copy of the discharge letter to YCCO, Attn: Enrollment Department, 503-376-7436. **IMPORTANT**: PCPs must provide urgent care for the discharged member for 30 days following notification of the member.
YCCO Care Coordinator	Work with YCCO Customer Service to assign the member to a new PCP.

Process For Discharging A Member

Member commits or threatens acts of physical violence and/or commits fraudulent or illegal activities

RESPONSIBILITY	ACTION
PCP or PCP staff	1. Immediately contact the police to file an official report. 7. Contact YCCO Care Coordinator to describe the incident. 8. Fax chart notes and police report when available to Care Coordinator. A member may be discharged in the following situations: • Member commits act of violence to staff, property, or other patients. • Member commits an illegal or fraudulent act that is witnessed or confirmed by police investigation. This includes but is not limited to acts of theft, vandalism and/or forgery.
PCP or PCP staff	• If clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address, and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. • Notify the YCCO Care Coordinator, if applicable. **IMPORTANT**: PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

Process For Discharging A Member

VERBAL ABUSE – VERBAL ABUSE JUSTIFYING DISCHARGE

Verbal abuse *is abusive language that contains a menacing tone with the intent of threat and is often accompanied by physical and language clues.*

RESPONSIBILITY	ACTION
PCP or PCP staff	9. Document incident(s). 10. At discretion of Clinic Manager, contact police to file an official report. 11. Contact YCCO Care Coordinator to describe incident. 12. Fax chart notes and police report, if one was filed, to YCCO Care Coordinator. 13. If clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address, and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. 14. Notify the YCCO Care Coordinator. **IMPORTANT:** PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge. 1.

VERBAL ABUSE – VULGAR LANGUAGE

RESPONSIBILITY	ACTION
PCP or PCP staff	• Document incident(s) in member's chart. • Schedule a meeting with the member to negotiate a behavioral contract that clarifies expected behavior and consequences for violations.

Process For Discharging A Member

YCCO Care Coordinator	15. If contract is repeatedly violated, contact the YCCO Care Coordinator to describe the incident(s). 16. Fax chart notes and any behavioral contracts to YCCO Care Coordinator.
PCP or PCP staff	17. If discharge is mutually agreed upon by PCP and member, work with YCCO Customer Service to assign the member to a new PCP. 18. If clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address, and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. 19. Notify the YCCO Care Coordinator. **IMPORTANT**: PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.

DISCHARGE FROM PCP BY MUTUAL AGREEMENT BETWEEN THE MEMBER AND THE PROVIDER

RESPONSIBILITY	ACTION
PCP or PCP staff	1. Document date and reason for mutual decision. 2. Try to find another provider within the primary care clinic to manage the member's care. 3. If another provider is not available within the clinic and clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address, and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. 4. Notify the YCCO Care Coordinator. **IMPORTANT**: PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.
YCCO Care Coordinator	5. Work with YCCO Customer Service to assign the member to a new PCP.

PROVIDER AND YCCO AGREE THAT ADEQUATE, SAFE, EFFECTIVE CARE CAN NO LONGER BE PROVIDED FOR A MEMBER	
RESPONSIBILITY	**ACTION**
PCP or PCP staff	1. Document date and reason for mutual decision. 2. Try to find another provider within the primary care clinic to manage the member's care. 3. If another provider is not available within the clinic and clinic management decides to discharge the member, send a letter to the member informing them of the discharge. The letter must include the reason for the discharge and any action(s) taken to resolve the issue. The letter must also include the member's name, date of birth, address, and client number. If any of the above information is missing, the discharge may not be process by YCCO and the letter will be returned to the clinic. 4. Notify the YCCO Care Coordinator. **IMPORTANT**: PCPs must provide urgent care for the discharged member for 30 days after the member is notified of the discharge.
YCCO Care Coordinator	5. Work with YCCO Customer Service to assign the member to a new PCP.